AUTHORIZATION REQUEST

Purchase of Medical Care Services
DHHS – Controller's Office

Read Instructions on Back

1. Last Name First Name MI

2. Patient SS # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

3. Date of Birth ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
Month Day Year

4. Sex ☐ 1. Male ☐ 2. Female

5. Race ☐ 1. White ☐ 2. Black ☐ 3. American Indian ☐ 4. Asian ☐ 5. Native Hawaiian/Other Pacific Islander ☐ 6. Unknown

Ethnicity: Hispanic or Latino Origin? ☐ Yes ☐ No ☐ Unknown

6. Preferred Language _____ Select from the list on the back of this form

7. County of Residence

8. Address Street or RFD

9. City State Zip Code

10. Telephone # Home Work

12. Program
ADAP

13. Authorization Number

14. POMCS Case Number

15. Provider of Requested Service

PHARMACARE 1-800-238-7828

16. Requested dates of service

17. Service is authorized for the following dates:

11. Alternate Contact Last First Middle Phone #:

18. Diagnostic Code/Diagnosis: Primary Secondary

19. Insurance or Third Party Policy # Policyholder Claims Address
(Attach copies of all Insurance Cards)

Does this policy cover this service? ☐ Yes ☐ No Is this an HMO? ☐ Yes ☐ No **If an HMO, documentation is required. See reverse.**

20. COMPLETE FOR ALL HIV REQUESTS

A. CD_4 Count _____

Date _____/_____/_____

B. Viral Load _____

Date_____/_____/_____

21. **Ship medications to:**

Care of, if applicable:

Street Address:

State Rd/RFD:

City:

State/Zip Code:

22. FOR ALL HIV REQUESTS

Clinician's Information:

Phone #:

Fax #:

DEA #:

NC License #:

23. Requesting Office

Agency:

Contact:

Address:

Phone #:

Date: ___ ___ ___ ___ ___ ___ ___ ___
Month Day Year

24A. Type or print Clinician's name

24B. Clinician's Signature (*I certify that the above named individual has prescriptions for medications listed on the current NC ADAP Formulary.*)

INSTRUCTIONS

PURPOSE

This form is used to request authorization for reimbursement from the ADAP program.

To qualify for payment, an applicant must be eligible for the program and an Authorization Request must be received within one year after the date of service. Processing time is reduced when this form is legible and complete. If requested, additional information must be received within one year after the date of service or within 30 days of notification, whichever is later. Incomplete forms will be returned.

Authorization Requests should be submitted without documentation if necessary to meet deadlines. Requests will not be processed until all information is received.

INSTRUCTIONS FOR COMPLETING CERTAIN ITEMS ON THIS FORM

6. Select one of the following languages and enter the 2 letter code in block 6 on the front of this form.

Arabic (AR)	Gujarati (GU)	Miao (MI)	Serbo-Croatian (SC)
Cambodian (CA)	Hindi (HI)	Mon-Khmer (MK)	Spanish (SP)
Chinese (CH)	Hmong (HM)	**Other (OT)**	Tagalog (TA)
English (EN)	Hungarian (HU)	Persian (PE)	Thai (TH)
French (FR)	Italian (IT)	Poland (PO)	Urdu (UR)
French Creole (FC)	Japanese (JA)	Portuguese (PG)	Vietnamese (VI)
German (GE)	Korean (KO)	Portuguese Creole (PC)	
Greek (GR)	Laotian (LA)	Russian (RU)	

10., 22., 23. Include area code with phone number.

13., 17. For POMCS use only. Do not complete these items.

18. Provide ICD-9 code if available. **Diagnosis should correspond to requested service.**

19. Provide complete insurance information. Attach copies of all insurance cards. Submit HMO denial or statement of benefits **if** HMO does not cover or partially covers requested service.

21. Medication is shipped to patient's home unless alternate address is listed here.

22. For HIV Program, enter clinician's telephone number, fax number, DEA number and NC License number.

24. Reserved for clinician's name and signature.

Fax or mail request. Do not do both.

MAIL REQUESTS TO: Purchase of Medical Care Services
DHHS-Office of the Controller
1904 Mail Service Center
Raleigh, NC 27699-1904

Faxed Authorization Requests are not given priority. Requesting offices should contact POMCS regarding the need to expedite a request.

BILLING INSTRUCTIONS

After a service has been authorized and provided, claims should be submitted to the POMCS Claims Processing Unit, DHHS-Office of the Controller, 1904 Mail Service Center, Raleigh, NC 27699-1904. All third party payors must be billed. Providers must wait for payment or denial or wait up to six months, whichever comes first, before billing a POMCS program. **All claims must be received within one year after the date of service in order to be paid.** Additional billing information is available upon request.

HOW TO ORDER THIS FORM

Additional forms may be orderd by faxing a request to 919-733-0352 or calling 919-855-3672.

WEBSITE: www.ncdhhs.gov/control/pomcs/pomcs.htm

ADAP WEBSITE: www.epi.state.nc.us/epi/hiv/adap.html